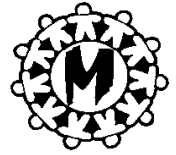




OAHU REGION
HAWAII HEALTH SYSTEMS CORPORATION



BED-HOLD AGREEMENT

I, _____, resident of this facility being discharged on _____.
acknowledge that I have been given Notice of the facility's Bed-Hold and Readmission policy.

I AGREE/DISAGREE (circle one) to Bed-Hold for _____ days and to pay the daily rate* of
\$_____ for the current room accommodation, effective the date after discharge, for the period
from _____ to _____ OR until date of cancellation.

Signature of Resident Date
Signature of Witness Date

RESIDENT REPRESENTATIVE

On behalf of _____, resident of this facility being discharged on
_____, I, _____ resident's representative,
acknowledge that I have been given Notice of the facility's Bed-Hold and Readmission policy.

I AGREE/DISAGREE (circle one) to Bed-Hold for _____ days and to pay the daily rate* of
\$_____ for current room accommodation, effective the date after discharge, for the period from
_____ to _____ OR until date of cancellation.

Signature of Resident's Representative Date
Signature of Witness Date

*Skilled or Intermediate Level of Care in private, semi-private, or ward accommodation

Amount due is _____ days at \$_____ per day for a total of \$_____.

If additional days are necessary, a new Bed-Hold Agreement must be executed.

Return form and payment payable to the appropriate facility below within 24 hours of resident's discharge.

- Leahi Hospital Call Business Office 733-7960 or Nursing Supervisor 220-3798 for information
Maluhia Call Financial Counselor 832-6136 or Nursing Supervisor 832-6177 for information

Original - Medical Records
Copy - Resident/Responsible Party & Business Office.

ORADM (P) 005 Rev 1/16